III. Wage Index Changes

Under section 1833(t)(2)(D) of the Act, we are required to determine a wage adjustment factor to adjust for geographic wage differences, in a budget neutral manner, that portion of the OPPS payment rate and copayment amount that is attributable to labor and labor-related costs.

We used the proposed Federal fiscal year (FY) 2002 hospital inpatient PPS wage index to make wage adjustments in determining the proposed payment rates set forth in this proposed rule. The proposed FY 2002 hospital inpatient wage index published in the May 4, 2001 **Federal Register** (66 FR 22821) is reprinted in this proposed rule as Addendum H, Wage Index for Urban Areas; Addendum I, Wage Index for Rural Areas; and Addendum J, Wage Index for Hospitals That Are Reclassified. We propose to use the final FY 2002 hospital inpatient wage index to calculate the payment rates and coinsurance amounts that we will publish in the final rule implementing the OPPS for calendar year (CY) 2002.

IV. Copayment Changes

We note that in section 1833(t) of the Act, the terms "copayment" and "coinsurance" appear to be used interchangeably. To be consistent with CMS usage, we make a distinction between the two terms throughout this preamble. We propose to make conforming changes to part 419 of the regulations to reflect the following usage:

- "Coinsurance" means the percent of the Medicare-approved amount that beneficiaries pay for a service furnished in the hospital outpatient department (after they meet the Part B deductible).
- "Copayment" means the set dollar amount that beneficiaries pay under the OPPS. For example, if the payment rate for an APC is $200 and the beneficiary is responsible for paying $50, the copayment is $50 and the coinsurance is 25 percent.

A. BIPA 2000 Coinsurance Limit

As discussed in section I.C of this preamble, certain provisions of BIPA 2000 affect beneficiary copayment amounts under the OPPS. Section 111 of the BIPA added section 1833(t)(8)(C)(ii) of the Act, to accelerate the reduction of beneficiary copayment amounts, providing that,

for services furnished on or after April 1, 2001 and before January 1, 2002, the national unadjusted coinsurance for an APC cannot exceed 57 percent of the APC payment rate. The statute provides for further reductions in future years so that the national unadjusted coinsurance for an APC cannot exceed 55 percent in 2002 and 2003, 50 percent in 2004, 45 percent in 2005, and 40 percent in 2006 and thereafter.

We implemented the reduction in beneficiary copayments for 2001 effective April 1, 2001 through changes to the OPPS PRICER software used to calculate OPPS payments to hospitals from the Medicare Program and beneficiary copayments.

We would revise § 419.41 to conform the regulations text to this provision.

B. Impact of BIPA 2000 Payment Rate Increase on Coinsurance

Under the statute as enacted by BBA 1997, APC payment rates for 2001 were to be based on the payment rates for 2000 increased by the inpatient hospital market basket percentage increase minus 1 percentage point; however, section 401 of the BIPA 2000 increased APC payment rates for 2001 to reflect an update based on the full market

basket percentage increase. The Congress intended for the increased payment to be in effect for the entire calendar year 2001; however, to provide us sufficient time to make the change, the Congress adopted a special payment rule for 2001. Under section 401(c) of the BIPA, the payment rates in effect for services furnished on or after January 1, 2001 and before April 1, 2001 are the rates as determined under the statute prior to the enactment of BIPA. For services furnished on or after April 1, 2001 and before January 1, 2002 the payment rates reflect the full market basket update and are further increased by 0.32 percent to account for the timing delay in implementing the full market basket update for 2001. The 0.32 percent increase is a temporary increase that applies only to the period April 1 through December 31, 2001 and is not considered in updating the OPPS conversion factor for 2002. The increase in APC payment rates for 2001 was implemented effective April 1, 2001 through changes to the OPPS PRICER software. We would revise § 419.32 to conform to the statute.

The section 401 increase to the APC payment rates affected beneficiary copayments in several ways. In cases for which the beneficiary coinsurance was already based on

20 percent of the APC payment rate, the increase in the APC payment rate caused a corresponding increase in the copayment for the APC. For all other APCs, the copayment amount remained at the same level. In addition, because the minimum copayment amount for an APC, which is the lowest amount a provider may elect to charge, if it chooses to reduce copayments for an APC, is based on 20 percent of the APC amount, the increase to an APC payment rate under section 401 of BIPA, resulted in an increase to the minimum copayment amount for each APC.

C. Coinsurance and Copayment Changes Resulting from Change in an APC Group

National unadjusted copayment amounts for the original APCs that went into effect on August 1, 2000 were, by statute, based on 20 percent of the national median charge billed for services in the APC group during calendar year 1996, trended forward to 1999, but could be no lower than 20 percent of the APC payment rate. Although the BBA 1997 specified how copayments were to be determined initially, the statute does not specify how copayments are to be determined in the future as the APC groups are recalibrated or as individual services are reclassified from one APC

group to another. In this section, we are proposing the method we intend to apply in determining copayments for new APCs (that is, those created after 2001) and for APCs that are revised because of recalibration and reclassification.

In developing a proposed approach to be used in determining copayments for new or revised APCs, we took into account the following:

- One of the Congress's goals in authorizing an OPPS is to reduce beneficiary copayment liability until the copayment for every hospital outpatient service equals 20 percent of the prospectively determined payment rate for that service. Therefore, when given two possible copayment amounts or coinsurance percentages for a service as the result of an APC change, we should opt for the lower value.

- In general, we should use the coinsurance percentage (that is, the percentage of the total payment rate represented by the copayment amount) as the factor for comparison of the old versus the new copayment amount rather than a copayment dollar amount.

- Notwithstanding any changes, the coinsurance for an APC cannot be lower than 20 percent of the payment rate for an APC group.

- Notwithstanding any changes, the coinsurance for an APC cannot exceed 55 percent of the payment rate for an APC in 2002 or the applicable copayment limits under section 1833(t)(8)(C)(ii) of the Act in subsequent years.

The following describes how we propose to determine copayment amounts for new and revised APCs for 2002 and subsequent years:

1. If a newly created APC group consists of services that were not included in the 1996 data base or whose charges were not separately calculated in that data base (that is, the services were excluded or packaged) the unadjusted copayment amount would be 20 percent of the APC payment rate.

2. If recalibrating the relative payment weights results in an APC having a decrease in its payment rate for a subsequent year, the unadjusted copayment amount will be calculated so that the coinsurance percentage for the APC remains the same that it was before the payment rate decrease. For example, assume the APC had a payment rate of $100 and an unadjusted copayment amount of $50, resulting in a coinsurance percentage of 50 percent. If the new payment rate for the APC is lowered to $80, the

copayment amount is calculated using the prior coinsurance percentage of 50 percent; therefore, the new copayment amount would be 50 percent of $80 or $40.

3. If recalibrating the relative payment weights results in an APC having an increase in its payment rate for a subsequent year, the unadjusted copayment amount would be calculated so that the copayment dollar amount for the APC remains the same as it was before the payment rate increase. That is, the unadjusted copayment amount would not change. For example, assume the APC had a payment rate of $100 and an unadjusted copayment amount of $60 (a coinsurance percentage of 60 percent). If the new payment rate for the APC is increased to $150, the unadjusted copayment amount would remain at $60 (a coinsurance percentage of 40 percent).

4. If a newly created APC group consists of services from two or more existing APCs, the unadjusted copayment amount would be calculated based on the lowest coinsurance percentage of the contributing APCs. For example, a new APC is created by moving some or all of the services from two existing APCs into the new APC. Assume that one contributing APC had a payment rate of $100 and an

unadjusted copayment amount of $40, coinsurance percentage of 40 percent. Assume the other contributing APC had a payment rate of $150 and an unadjusted copayment amount of $75, a coinsurance percentage of 50 percent. If the new APC had a payment rate of $130, the unadjusted copayment amount for the new APC would be based on a coinsurance percentage of 40. The unadjusted copayment amount for the new APC would be 40 percent of $130, or $52.

5. If an APC payment rate is increased due to a conversion factor update, the unadjusted copayment amount for the APC would not change.

V. Outlier Policy Changes

For OPPS services furnished before January 1, 2002, section 1833(t)(5)(D) of the Act explicitly authorizes the Secretary to apply the outlier payment provision based upon all of the OPPS services on a bill. We exercised that authority and, since the beginning of the OPPS on August 1, 2000, we have calculated outlier payments in the aggregate for all OPPS services that appear on a bill. Under this proposed rule, beginning January 1, 2002, we will calculate outlier payments based on each individual OPPS service. We propose to revise the aggregate method that we are

currently using to calculate outlier payments and begin to determine outliers on a service-by-service basis for OPPS services furnished on or after January 1, 2002.

One difficulty we face with calculating outliers based on individual services is how to treat the charges for packaged services (for example, drugs, supplies, anesthesia, and equipment) when more than one OPPS service appears on a bill. These packaged services do not in themselves generate an APC payment but their charges must be taken into account to determine the cost of a service such as a surgical or diagnostic procedure or medical visit that does generate an APC payment. When more than one HCPCS code that will result in an APC payment appears on a bill, it is currently impossible to determine which packaged service is associated with an individual OPPS payable service. For example, when multiple surgical procedures are performed on the same day, we cannot determine how much of the operating room, drug, supply, anesthesia, or recovery room charge is attributable to each procedure. Similarly, if a medical visit and a surgical procedure occur on the same day, we cannot accurately determine how much of the charge for any drug, supply, or

other packaged service that appears on the bill is attributable to each individual OPPS service.

One solution would be to require hospitals to submit separate bills for each OPPS service so that we can be certain that the correct packaged services attributable to the individual OPPS service will be taken into account in determining an outlier payment for that service. We believe, however, such a requirement would be excessively burdensome to hospitals and would greatly increase fiscal intermediary workloads. In addition, billing of individual services for the same day on separate bills would prohibit us from applying the correct coding edits. Finally, we believe that the limit on outlier payments (up to 2.5 percent of the total OPPS payments in each year before 2004 and up to 3 percent for subsequent years) does not justify the burden that would result from requiring separate bills for each OPPS service.

Another approach we considered is to allocate the charges for any packaged service among the individual OPPS services that appear on the bill. We considered two possible ways to do this. First, we could divide the packaged charges equally among the OPPS services so that if

there were three services that generated APC payments, one third of the charges for the packaged services would be assigned to each OPPS service. We also considered dividing the total packaged charges among the OPPS services based on the ratio of the APC payment rate for an individual OPPS service to the total APC payment rates for all services on the bill. Thus, if a service resulted in an APC rate of $200 and the total APC payment rates for all services on the bill were $2,000, that individual APC would be allocated 10 percent of the packaged charges appearing on the bill.

We prefer using one of the approaches that would allocate packaged charges among the APCs on a bill to avoid disruptive billing changes. Of the two ways to allocate charges for packaged services, we are proposing that charges be allocated to each OPPS service based on the percent the APC payment rate for that service bears to the total APC rates for all OPPS services on the bill. We believe that this allocation method is somewhat more precise than simply dividing evenly the total packaged charges by the number of APCs on the bill.

We also propose to convert charges to costs for calculating outlier payments by continuing to apply a single overall hospital-specific cost-to-charge ratio instead of applying hospital-specific departmental cost-to-charge ratios. There is no universal crosswalk of revenue codes to cost report cost centers that is used by all hospitals. Although departmental cost-to-charge ratios are more precise for purposes of determining costs of specific services, hospitals have considerable discretion in assigning charges billed under specific revenue codes to specific departments on their cost reports. Therefore, we do not have a way of defining, in a uniform manner that is accurate for all hospitals, which department cost-to-charge ratio to apply to a revenue code billed by a hospital. We considered establishing a basic crosswalk that we would apply uniformly to every hospital, but this could result in a distorted or inaccurate model of how some hospitals actually assign charges. Given the appropriate resources, we could gather data from hospitals upon which to base a crosswalk specific to every hospital paid under the OPPS. But collecting these data would impose significant burden and administrative costs on hospitals and on our

contractors. Given that outliers represent only 2 to 3 percent of total OPPS expenditures, we believe that the increased accuracy in calculating outlier payments that we could gain would not be sufficient to justify the significant additional administrative burden and cost that would be required. For this reason, we are proposing to continue to apply a single hospital-specific outpatient cost-to-charge ratio to convert billed charges to costs for calculating outlier payments.

As explained in the April 7, 2000 final rule (65 FR 18498), we set a target for outlier payments at 2.0 percent of total payments. We also explained, for purposes of simulating payments to calculate outlier thresholds, that we set the parameters for determining outlier payments as if the target were 2.5 percent. We believed that it would be likely that using simulation 1996 claims data would overstate the percentage of payments that would be made. Based on the simulations, we set a threshold for outlier payments at 2.5 times the claim cost and a payment percent of 75 percent of the cost above the threshold for both 2000 and 2001.

In setting the 2002 outlier threshold and payment percentage, we account for the charge to service level rather than claim level outlier calculation. In this proposed rule, we would again set the target for outlier payment at 2.0 percent. However, because we believe that the claims data we are using to set the 2002 proposed payment rates reflect much better coding of services than did the 1996 data, we would set these parameters to reach a target of 2.0 percent (rather than 2.5 percent). Based on our simulations, the proposed threshold for 2002 is 3 times the service costs and the proposed payment percentage for costs above that threshold is set at 50 percent.